

Step Therapy Authorization Request

Member Information (required)		Provider Information (required)	
Member Name:		Provider Name:	Specialty:
ID#:		NPI#:	Contact Person
Date of Birth:		Office Phone:	Office Fax:
Pharmacy Information			
Pharmacy Name:		Pharmacy NPI:	
Pharmacy Phone:		Pharmacy Fax:	
Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
Directions for use:			

All information to be legible, complete and correct or form will be returned. FAX DOCUMENTATION INCLUDING PROGRESS NOTES or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

Criteria for Approval:

AT LEAST ONE OF THE FOLLOWING CONDITIONS MUST BE MET:

- ☐ Trial and failure of at least one preferred drugs in the drug class:
 Medication(s) used: _____
 Details of failure: _____
 Chart Note Page #: _____
- ☐ Detailed evidence of a contraindication to a preferred drug.
 Chart Note Page #: _____
- ☐ Detailed evidence of patient's adverse event(s) with preferred drugs or high risk of adverse events with preferred drugs.
 Chart Note Page #: _____

Re-authorization Criteria:

Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.

Initial Authorization: One (1) year

Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

 Prescriber's Signature

 Date